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IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

CALIFORNIA AMBULANCE ASSOCIATION
AND CALIFORNIA MEDICAL ASSOCIATION, *et al.*,
Petitioners,

v.

S. KIMBERLY BELSHE, DIRECTOR OF THE
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

and

DONNA E. SHALALA, SECRETARY OF THE
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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23 pp

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTRODUCTION AND INTEREST OF THE AMICUS CURIAE	1
REASONS FOR GRANTING THE PETITION	4
I. CONGRESS' RETROACTIVE APPLICATION OF SECTION 4714 IS A DANGEROUS PRECEDENT FOR THE FUTURE INTEGRITY OF FEDERAL CONTRACTING PROGRAMS	7
A. The Premises of Congress' "Clarification" Pose Issues of Great National Concern Affecting Federal Health Programs and All Government Contracts	7
B. This Case Presents Important Corollary Considerations to this Court's Recent Decision in *Eastern Enterprises*	10
II. CERTIORARI SHOULD BE GRANTED TO RESOLVE THE QUESTION OF "DEFERENCE" OWING TO A LATER CONGRESS' ATTEMPTED RETROACTIVE REPUDIATION OF AN ENACTING CONGRESS' INTENT	13
A. There Are Important Public Policy Grounds for Congress' Historical Attention to the QMB Population	14
B. Because the Acts of Congress in 1986 and 1988 Conflict With Its "Clarifying" Words in 1997, the Ninth Circuit's Deference to the Later Enactment Merits Close Scrutiny	15
CONCLUSION	18

TABLE OF AUTHORITIES

Cases	Page
Armstrong v. United States, 364 U.S. 40 (1960)	11
Beverly Community Hospital Assn. v. Belshe, 132 F.3d 1259 (CA9 1997)	6
Bowen v. Public Agencies Opposed to Social Security Entrapment, 477 U.S. 41 (1986)	12
California Ambulance Assn. v. Shalala, No. CV96-2322 JSL (C.D. Cal. July 25, 1996)	6
Eastern Enterprises v. Apfel, —— U.S. ——, 118 S.Ct. 2131 (1998)	10, 11, 12, 13
Haynes Ambulance Serv., Inc. v. Alabama, 36 F.3d 1074 (CA 11 1994)	6
Louisville Joint Stock Land Bank v. Radford, 295 U.S. 555 (1935)	12
Lynch v. United States, 292 U.S. 571 (1934)	9
New York City Health and Hospitals Corp. v. Perales, 954 F.2d 972 (CA 2 1992)	6, 16
Paramount Health Systems, Inc. v. Wright, 138 F.3d 706 (CA 7 1998)	13
Pennsylvania Medical Soc'y. v. Snider, 29 F.3d 886 (CA 3 1994)	6
Pension Benefit Guaranty Corp. v. R.A. Gray & Co., 467 U.S. 717 (1984)	8
Perry v. United States, 294 U.S. 330 (1935)	9
Rehabilitation Assn. of Virginia, Inc. v. Kozlowski, 42 F.3d 1444 (CA 4 1994)	6
United States v. Larionoff, 431 U.S. 864 (1977)	9
United States v. Security Industrial Bank, 459 U.S. 70 (1982)	11
United States v. Winstar Corp., 518 U.S. 839, 116 S.Ct. 2432 (1996)	9
Usery v. Turner-Elkhorn Mining Co., 428 U.S. 1 (1976)	11
Webb's Fabulous Pharmacies, Inc. v. Beckwith, 449 U.S. 155 (1980)	11

Statutes	
42 U.S.C. § 1395 *et seq.*	4
42 U.S.C. § 1395ss	17
42 U.S.C. § 1396 *et seq.*	4

TABLE OF AUTHORITIES—Continued

	Page
42 U.S.C. § 1396a(a)(10)(E)	5, 9
42 U.S.C. § 1396a(a)(15) (repealed)	5
42 U.S.C. § 1396b	9
42 U.S.C. § 1396d(p)(1)	5
42 U.S.C. § 1396d(p)(3)	5, 16
Balanced Budget Act of 1997 §§ 4501-4505, Pub. L. 105-33, 111 Stat. 432-437	8
Balanced Budget Act of 1997 § 4714, Pub. L. 105-33, 111 Stat. 509	*passim*
Pub. L. 99-509 § 9403, 100 Stat. 2053 (1986)	5
Pub. L. 100-360 § 221(d), 102 Stat. 744 (1988)	17
Pub. L. 100-360 § 301, 102 Stat. 748 (1988), as amended by Pub. L. 100-485 § 608, 102 Stat. 416 (1988)	5
Pub. L. 100-647 § 8434(a), 102 Stat. 3805 (1988)	5
Pub. L. 101-234 § 203(a), 103 Stat. 1982 (1989)	17
Pub. L. 101-508 § 4351(a), 104 Stat. 1388-125 (1990)	17
Regulations	
57 Fed. Reg. 37,985 (August 21, 1992)	17
62 Fed. Reg. 62,613 (November 24, 1997)	9
Other Authorities	
H.R. Rep. No. 99-727, 99th Cong., 2d Sess. 105-106 (1986)	15
Health Care Financing Administration, A Profile of Dually Eligible Beneficiaries (March, 1997)	14, 16
Physician Payment Review Commission, Annual Report to Congress (April, 1997)	17
Physician Payment Review Commission, Physician Payment Under Medicaid, No. 91-4 (1991)	12, 18
Rowland, D. and B. Lyons, "Medicare, Medicaid, and the Elderly Poor," Health Care Financing Review (Winter, 1996)	2
U.S. Department of Health and Human Services, 1996 HCFA Statistics (September 1996)	8

TABLE OF AUTHORITIES—Continued

Page

U.S. House of Representatives, Committee on Ways and Means, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means, Committee Print No. 104-14, 104th Cong. 2d Sess. (1996) 7, 8

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INTRODUCTION AND INTEREST OF THE AMICUS CURIAE [1]

Medicare has covered the health care needs of the elderly and disabled for more than 30 years, and pays

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[1] Letters from all parties consenting to the filing of this brief have been lodged with the Clerk of the Court. Pursuant to Rule 37.6, counsel for *amicus curiae* are not counsel for any party in this case, but appear *of counsel* on two petitions pending before the Court concerning the identical issue presented in this case: *Gilmore v. Belshe*, No. 97-1949, which was consolidated with this case before

roughly 80 percent of the federally-approved charges for medical services. Many Medicare beneficiaries are both poor and aged or disabled (known as Qualified Medicare Beneficiaries, or "QMBs"). State Medicaid programs have long been required to supplement the federal payment for the care of QMBs, satisfying the copayments otherwise expected from beneficiaries.

Significant numbers of willing physicians, among other health care providers and suppliers, are counted on to deliver the care those individuals require.[2] Medicare has secured the service of physicians, at least in part, by setting out in advance the terms on which they and other providers or suppliers would be paid. Medical professionals have rendered services in reliance on the government's promise to pay in accordance with statutory rules.

After disputes arose, physicians successfully enforced the terms of the statutes that govern payment for services to QMBs in all federal appellate decisions before August of 1997. Faced with the adverse decisions, state and federal governments persuaded Congress in that month to enact new rules that also purported to repudiate obligations already incurred. This and related cases ensued.

The implications of the decision at issue here (which upheld the retroactive act) extend beyond Medicare and the QMB context. The decision below effectively invites Congress and the state and federal governments to change the terms of payment for services already rendered whenever budgetary pressures make it convenient. The legislature would need only to declare a governing statute in

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the Ninth Circuit Court of Appeals below, and *Paramount Health Systems, Inc. v. Wright*, No. 97-2029. A petition for certiorari also has been filed in a third consolidated case from the Ninth Circuit, *Beverly Community Hospital Assn. v. Belshe*, No. 97-1947.

[2] The size of this population is significant. One in five elderly Americans, for example, lives in or near poverty. *See* D. Rowland and B. Lyons, "Medicare, Medicaid, and the Elderly Poor," *Health Care Financing Review* at 61 (Winter, 1996).

need of "clarification" and then proceed to change it and avoid all constitutional infirmity. Sizable federal outlays for programs such as Medicare and Medicaid present all too tempting a target for financially advantageous turnabouts.

If Congress may so easily defeat a provider's right to payment for work already performed, the stability of all government contracting programs can no longer be assured. Contractors such as physicians will be much less likely to participate in government programs, and the availability of services for Medicare beneficiaries and others whom the programs are meant to help—including the general public—will inevitably decline.

Amicus curiae, American Medical Association ("AMA"), is a private, voluntary nonprofit organization of physicians, founded in 1847 to promote the science and art of medicine and to improve the public health. The AMA is a national advocate on behalf of physicians and their patients in regard to legal and regulatory issues affecting the practices of medicine. Its 290,000 physician members practice in all states and in all fields of medical specialization, and include a significant number of physicians throughout the United States who serve Qualified Medicare Beneficiaries.

The AMA/State Medical Society Litigation Center ("Litigation Center") is a coalition of the AMA and 46 private, voluntary, nonprofit state medical societies formed in 1995 to represent the views of organized medicine in the courts.[3] The Litigation Center has been active

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[3] The member organizations are: Medical Association of the State of Alabama, The Alaska State Medical Association, Arkansas Medical Society, California Medical Association, Colorado Medical Society, Connecticut State Medical Society, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, Hawaii Medical Association, Idaho Medical Association, Illinois State Medical Society, Indiana State Medical Association, Iowa Medical Society, Kansas Medical Society, Kentucky Medical Association, Louisiana State

in efforts to ensure proper implementation of QMB payment policies established by Congress. These efforts initially included attempts to resolve QMB payment issues through negotiations with the federal Health Care Financing Administration. When those attempts proved unavailing, the AMA continued with active assistance to state medical societies in litigation. The AMA lobbied actively, albeit unsuccessfully, against Congress' efforts to repudiate contractual QMB payment obligations through the Balanced Budget Act of 1997—the statute which now is the centerpiece of this litigation.

The American Medical Association, as *amicus curiae*, urges that the petition for certiorari be granted.

REASONS FOR GRANTING THE PETITION

As more fully set forth in the Petitioners' Statement, this case concerns the interaction of the Medicare program (42 U.S.C. § 1395 et seq.) and the Medicaid program (42 U.S.C. § 1396 et seq.) in paying for the health care of individuals designated as "Qualified Medicare Beneficiaries" or "QMBs."[4] Since 1988 and prior to

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Medical Society, Maine Medical Association, Massachusetts Medical Society, Michigan State Medical Society, Minnesota Medical Association, Mississippi State Medical Association, Missouri State Medical Association, Montana Medical Association, Nebraska Medical Association, New Hampshire Medical Society, Medical Society of New Jersey, New Mexico Medical Society, Medical Society of the State of New York, North Carolina Medical Society, North Dakota Medical Association, Ohio State Medical Association, Oklahoma State Medical Association, Oregon Medical Association, Pennsylvania Medical Society, Rhode Island Medical Society, South Carolina Medical Association, Tennessee Medical Association, Texas Medical Association, Utah Medical Association, Vermont State Medical Society, Washington State Medical Association, West Virginia State Medical Association, State Medical Society of Wisconsin, Wyoming Medical Society.

[4] The "QMB" population consists of two groups of Medicare beneficiaries: (1) "dual-eligibles" who simultaneously meet their state's eligibility criteria for full Medicaid benefits, including entitlement to have Medicaid pay, on their behalf, the prescribed

August 5, 1997, federal law required the State of California's Medicaid program to pay certain Medicare costs in full on behalf of QMBs, specifically including the 20 percent coinsurance for physician and other medical services covered under Part B of Medicare.[5]

Both the obligation to make payments on behalf of QMBs and a specific definition of the payments to be made are set forth in the statute. 42 U.S.C. §§ 1396(a)(10)(E), 1396d(p)(3). Rather than paying the statutorily prescribed Medi*care* amount, however, California limited these payments according to its own Medi*caid* fee schedule. Physicians in California challenged these payment limitations in litigation, following the path of physicians in other states with similar limitations. All four courts of appeal to have addressed the issue prior to 1997, as well as the District Court below, held that such payment limitations were unlawful and that physicians and other providers of health care services to QMBs were

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Medicare cost sharing amounts and (2) "pure QMBs" who meet alternative eligibility criteria under federal law which entitle them only to Medicaid payment, on their behalf, of the prescribed Medicare cost sharing amounts. *See* 42 U.S.C. § 1396d(p)(1).

[5] State Medicaid coverage of Medicare cost sharing amounts on behalf of "dual eligibles" was mandatory from the enactment of the original legislation in 1965, pursuant to 42 U.S.C. § 1396a(a)(15). That provision also permitted states to impose a responsibility to pay a nominal portion of the Medicare cost sharing on the dual eligible beneficiary. In 1986, states were authorized (but not required) to pay Medicare cost sharing on behalf of "pure QMBs" pursuant to legislation which, *inter alia*, added the current statutory definition of "Medicare cost sharing." Pub. L. 99-509 § 9403, 100 Stat. 2053 (1986). In 1988, Congress repealed § 1396a(a)(15), eliminated the statutory distinction between dual eligibles and pure QMBs, and made state payment of "Medicare cost sharing" (as defined in 1986) on behalf of all QMBs a mandatory component of approved state Medicaid plans. Pub. L. 100-360 § 301, 102 Stat. 748 (1988), as amended by Pub. L. 100-485 § 608, 102 Stat. 416 (1988); Pub. L. 100-647 § 8434(a), 102 Stat. 3805 (1988). The new statutes contained no provision analogous to § 1396a(a)(15) authorizing states to impose part of the payment responsibility on another party.

entitled to payment of the full Medicare rate for Medicare services rendered to QMBs.[6]

Congress interceded in the dispute by enacting Section 4714 of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 509 (August 5, 1997) ("Budget Act"). The Budget Act added new provisions purporting to "clarify" the authority of California and other states to limit benefits paid on behalf of QMBs. The Budget Act, at § 4714(c), also applies the new provisions retroactively, but only to health care providers that assert legal claims to payment for services rendered under prior law.

The Court of Appeals below concluded that Congress' expressed intent to "clarify" the prior law was entitled to "great weight." *Beverly Community Hospital Assn. v. Belshe*, 132 F.3d 1259, 1265 (CA9 1997). Viewing the new law as a clarification, the Court of Appeals concluded that Petitioners' constitutional objections to the retroactive effect of the Budget Act were obviated. *Id.* at 1266. The Ninth Circuit seems to have elevated this Court's holdings on judicial deference above constitutional takings and due process limitations, while simultaneously disregarding Congress' usurpation of the judicial function to direct the outcome of cases in which the United States is a party.

Beyond the reasons presented by Petitioners, *amicus curiae* AMA urges two additional reasons in support of the petition for a writ of certiorari to the Ninth Circuit.

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[6] *Rehabilitation Ass'n. of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444 (CA 4 1994); *Haynes Ambulance Serv., Inc. v. Alabama*, 36 F.3d 1074 (CA 11 1994); *Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886 (CA 3 1994); *New York City Health and Hospitals Corp. v. Perales*, 954 F.2d 972 (CA 2 1992); *California Ambulance Assn. v. Shalala*, No. CV96-2322 JSL (C.D. Cal. July 25, 1996) (entering summary judgment for plaintiffs in this case), reprinted in the Appendix to the Petition for Certiorari at 26-28.

I. CONGRESS' RETROACTIVE APPLICATION OF SECTION 4714 IS A DANGEROUS PRECEDENT FOR THE FUTURE INTEGRITY OF FEDERAL CONTRACTING PROGRAMS.

A. The Premises of Congress' "Clarification" Pose Issues of Great National Concern Affecting Federal Health Programs and All Government Contracts.

Section 4714, in the guise of a "clarification," authorizes the states—as federal agents and on their own behalf—to repudiate their statutory obligations to pay physicians and other medical care providers to receive the promised statutory payment for services performed under prior law. The enactment undermines the core integrity of government at both state and federal levels.

Section 4714 stands as a blueprint for future forays through the *Federal Reporter* in search of adverse judicial decisions that can be "clarified" into budget savings. This potential is of great concern with respect to the Medicare and Medicaid programs, which are very large components of the federal budget and which, concomitantly, are economically important to millions of beneficiaries and thousands of individuals who provide health care services to them.

Federal Medicare and Medicaid outlays totaled approximately $250 billion in fiscal year 1995, making the federal government the largest single purchaser of health care services in this country. U.S. House of Representatives, Committee on Ways and Means, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, Committee Print No. 104-14, 104th Cong. 2d Sess. (1996) (the "Green Book") at 134, table 3-1, and 896, table 16-13. The importance of the Medicare and Medicaid programs is particularly great to the lives and well-being of those who are the beneficiaries of the programs. Approximately 4.5 million Qualified Medicare Beneficiaries in the United States are directly affected by the enactment of Section 4714. *Id.* at 221-22, table 3-42. But the impact of Section 4714's

retroactivity extends to all Medicare and Medicaid beneficiaries—some 72 million in number, *id.* at 135-36, table 3-2, and 897-98, table 16-14, because the premises of Congress' action are not bounded by the QMB provisions of the law.

Approximately 788,000 physicians throughout the United States are active in the Medicare program. U.S. Department of Health and Human Services, *1996 HCFA Statistics* (September 1996) at 6, table 23. Their continued voluntary participation, and therefore the availability of services to patient populations such as QMBs, is essential to the fulfillment of the program's objectives. Their participation ultimately depends on the integrity of the federal government as a fair and reliable contractor for their services.

The issue for providers is not simply fee adjustments. Health care providers have become well accustomed to annual reductions in Medicare and Medicaid fees, a tradition that continued in the 1997 Budget Act. *See* Budget *Act*, §§ 4501-4505. Changes to reduce Medicare and Medicaid expenditures have been a principal focus of every budget reconciliation bill in recent history. *See* Green Book at 235-36, table 3-43. The legislative process is understood and accepted as one in which policies may be altered with future effect.

But Section 4714 reaches deeper—not only authorizing future changes in QMB payment policy, but voiding past obligations as well. It renders future commitments regarding the administration of Medicare and Medicaid of scant value. Moreover, health care is but one of many sectors of the economy substantially affected by the government's direct or indirect procurement activities, and nothing inherent in Section 4714 prevents the extension of its premises to other contracting activities.

This is not an instance in which Congress provided for short-term retroactive effect in order to avert strategic behavior on the part of those affected by a prospective change in the law. *Compare Pension Benefit Guaranty*

Corp. v. R.A. Gray & Co., 467 U.S. 717, 729-30 (1984) (retroactive application of ERISA withdrawal liability amendments deemed rational where employers could defeat the purpose of amendments by withdrawing during lengthy legislative process). Any such strategic behavior was an impossibility—the services were long ago provided. Rather, Congress has reached back over a period of years— as far as the statute of limitations on claims for payment —to take for itself the value of services provided in order to create budget savings.[7]

As this Court has stated previously, legislative repudiation of contractual obligations is not an affirmation of sovereign power; it is the antithesis of such power under our constitutional scheme. *United States v. Winstar Corp.*, 518 U.S. 839, 116 S.Ct. 2432, 2464 and n.38 (1996) ("sovereign acts" doctrine was meant to serve, not undermine, principle that government's contract relations are governed generally by law applicable to private contracts; suggestion that government may abrogate contracts it had come to regret in "regulatory" cases would render federal sovereignty of "very little use" in broad sphere of public activity); *Lynch v. United States,* 292 U.S. 571, 579-80 (1934) (valid contracts are property; rights against the United States arising out of a contract with it may not be abrogated simply to save money); *Perry v. United States,* 294 U.S. 330, 354 (1935) (Congress exceeded its power insofar as it attempted to override obligations created by bonds of the United States); *see also United*

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[7] Although the direct obligation to make Medicare cost sharing payment on behalf of QMBs is imposed on the states, the Medicaid scheme of federal financial assistance requires the federal government to reimburse California for 51 percent (approximately) of those amounts paid. *See* 42 U.S.C. § 1396b (statutory authority for federal financial assistance); 62 Fed. Reg. 62,613, 62,614 (November 24, 1997) (current federal financial assistance percentages). In order to receive federal matching funds, the California Medicaid plan must conform to federal law, including 42 U.S.C. § 1396a(a)(10)(E) which mandates coverage of Medicare cost sharing for QMBs.

States v. Larionoff, 431 U.S. 864, 879 (1977) (suggesting that constitutional concerns of *Lynch* and *Perry* would be implicated by congressional action to reduce armed forces pay for services already performed).

Whatever the wisdom, as a matter of policy, of Congress' decision to change the basis of payment for QMBs for the future, its determination to relieve itself of the obligation to make full payment for services already performed substitutes legislative fiat for the orderly administration of federal contract programs under law. "If retroactive laws change the consequences of transactions long closed, the change can destroy the reasonable certainty and security which are the very objects of property ownership. . . . Both stability of investment and confidence in the constitutional system . . . are secured by [constitutional] restrictions against severe retroactive legislation." *Eastern Enterprises v. Apfel*, —— U.S. ——, 118 S. Ct. 2131, 2159 (1998) (Kennedy, J., concurring in the judgment and dissenting in part).

B. This Case Presents Important Corollary Considerations to This Court's Recent Decision in *Eastern Enterprises*.

This Court recently affirmed its view that retroactivity is "generally disfavored in the law, in accordance with fundamental notions of justice that have been recognized throughout history." *Eastern Enterprises v. Apfel*, —— U.S. ——, 118 S. Ct. 2131, 2151 (1998). The concern raised in *Eastern Enterprises* regarding unjust interference with legitimate and settled expectations is most acute when the character of the governmental action is revealed not only to place a disproportionate burden on one group of individuals, but to create, in turn, a direct fiscal benefit for the federal government as purchaser of those individuals' services.

This case presents a clear and useful opportunity to bring the *Eastern Enterprises* analysis to bear upon programs that involve the federal government's own obliga-

tions. The instant case presents compelling comparisons and contrasts to *Eastern Enterprises* which suggest not only a strong foundation on which to amplify a constitutional "takings" analysis but also an appropriate case in which to further explore the limits of retroactive legislation, whether under a takings or a due process framework.

The effect of Section 4714 is substantial—it completely extinguishes physicians' vested rights to payment under the prior statutory scheme. It works a permanent deprivation of those assets. Congress has directly specified the assets that physicians must forfeit, and the law's effect depends solely upon the confiscation of those assets. That is, they must donate a portion of their labors by giving up their identified claims. *See United States v. Security Industrial Bank*, 459 U.S. 70, 75 (1982) (amendment to Bankruptcy Act permitting debtors to avoid certain liens would work a "complete destruction" of a property right if applied retroactively); *Armstrong v. United States*, 364 U.S. 40, 49 (1960) (compulsory transfer of property to government rendering liens unenforceable constitutes a "taking" within the meaning of the Fifth Amendment; government may not force some people alone to bear burdens which should be borne by the public as a whole).

Significantly, unlike in *Eastern Enterprises*, the asserted taking here is *by* the government, not a separate entity. *See* 118 S. Ct. at 2162 (Breyer, J., dissenting). The extinguishment of physicians' claims serves only the government's self-enrichment. Section 4714 has no colorable purpose to adjust private relationships in order to improve the public condition. *Cf. Webb's Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 15, 163-64 (1980) (exaction of a forced contribution of private property to government cannot be viewed as an adjustment of the benefits and burdens of economic life to promote the common good). Likewise, the statute has no remedial purpose. *Compare Usery v. Turner-Elkhorn Mining Co.*, 428 U.S.

1, 18 (1976) (legislation requiring coal companies to bear liability for illnesses of former workers not irrational because companies and their customers had received the benefit of former workers' labor).[8] Section 4714 is purely a budgetary measure. It "remedies" only Congress' need to reduce federal expenditures. *See* Appendix to Petition for Certiorari at 44-48 (Congressional Budget Office estimate of reduction in federal outlays resulting from Section 4714).

Further, it cannot be said that physicians had any reasonable expectation that the federal government would impose a reduced rate of payment after the services were rendered,[9] and the fact that physicians were paid something does not mean that the lack of full payment is not a significant economic burden.[10] Section 4714 impairs substantive rights which were acquired before its enactment, by physicians' performance of services in reliance on the government's statutory offer. *See Louisville Joint Stock Land Bank v. Radford*, 295 U.S. 555 (1935) (amendment to Bankruptcy Act depriving mortgagees of previously acquired lien rights constitutes a taking in violation of the Fifth Amendment). There is no logical

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[8] This case is quite the opposite. Here, it is the federal and state governments that have received the benefit of physician services, but now seek to retroactively avoid the obligation to pay the promised rate in full.

[9] There is no agreement to future payment reductions here that can be analogized to the promises of lifetime benefits asserted (and ultimately found unpersuasive) in support of the challenged legislation in *Eastern Enterprises*. *See* 118 S.Ct. at 2152. Moreover, as this Court has stated previously, Congress' express reservation of rights to amend the Social Security Act does not extend to impairment of contractual obligations which confer vested rights. *Bowen v. Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 51-52 (1986).

[10] Medicare fee schedules, to begin with, are below the levels that commercial insurers deem "usual and customary." *See, e.g.*, Physician Payment Review Commission, *Physician Payment Under Medicaid*, No. 91-4 (1991) at 36.

dividing line between Section 4714 and a future law declaring prior services to have been rendered for free. A frightening "slippery slope" exists that only rejection of congressional power to repudiate the government's obligations can avoid.

Finally, unlike the suggestion made in *Eastern Enterprises*, 118 S.Ct. at 2150, physicians have no ability to enter into private contracts of indemnification or otherwise adjust their relationships with QMBs in response to the retroactive "clarification" of federal payment policy. Apart from the fact that the physicians have already performed their part of the bargain, Congress wholly foreclosed any private remedial measure by enacting, as part of Section 4714, a specific prohibition on seeking the balance of the promised payment from the beneficiaries. Budget Act § 4714(a).

Amicus curiae submits that the circumstances of Section 4714 present questions of compelling national interest, the same caliber as those recognized in *Eastern Enterprises*. For this reason, the writ of certiorari should issue to review the decision of the Ninth Circuit.

II. CERTIORARI SHOULD BE GRANTED TO RESOLVE THE QUESTION OF "DEFERENCE" OWING TO A LATER CONGRESS' ATTEMPTED RETROACTIVE REPUDIATION OF AN ENACTING CONGRESS' INTENT.

The Ninth Circuit below and, with greater expressed reluctance, the Seventh Circuit in *Paramount Health Systems, Inc. v. Wright*, 138 F.3d 706, 710-711 (CA 7 1998), concluded that this Court's precedents required deference to Congress' 1997 interpretation of its 1986 intent regarding QMB payments. Apart from the plain fact that the clarification comes eleven years after the fact, good reasons exist to question this newly-revealed legislative discernment. These reasons flow, *inter alia*, from the context in which the QMB provisions originally were enacted, which suggests that Congress made clear choices to ensure that QMBs would receive full Medicare benefits,

and did so as part of an overall legislative scheme to regulate Medicare supplemental insurance. These circumstances argue against giving unquestioning deference to Congress' later interpretation and in favor of Petitioners' request for clarification of the standard of review in such cases.

A. There Are Important Public Policy Grounds for Congress' Historical Attention to the QMB Population.

Congress' historical interest in protecting the QMB population is well grounded. The population is diverse but has substantial health care needs.[11] By definition, all QMBs are individuals of limited economic means. They include both elderly Medicare beneficiaries and non-elderly Medicare beneficiaries who are disabled. The disabled and the so-called "frail elderly" (those aged 85 and over) are more likely to be eligible for both Medicare and Medicaid. Compared to the general Medicare population, QMBs are more likely to be minorities, female, and living alone.

QMBs report significant health problems. Over forty percent of these individuals have a cognitive or mental impairment, compared to nine percent of the non-QMB Medicare population. Half of Medicare beneficiaries with Alzheimer's Disease or a psychiatric disorder, and two-thirds of Medicare beneficiaries with mental retardation, are QMBs. This population is twelve times more likely than non-QMB Medicare beneficiaries to reside in a nursing home or other institution. Similarly, QMBs are more likely than their non-QMB counterparts to have chronic and/or serious medical conditions, such as stroke, chronic heart disease, diabetes, broken hips, or paralysis. Half of

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[11] The description of the QMB population presented in this section is drawn from: Health Care Financing Administration, *A Profile of Dually Eligible Beneficiaries* (March, 1997). The Health Care Financing Administration is the component of the U.S. Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

QMBs describe their own health status as "fair" or "poor," twice the rate of non-QMB Medicare beneficiaries.

QMBs face problems of access to health care directly related to their inadequate financial resources. They cannot afford to pay the premiums for Medicare Part B, the voluntary portion of Medicare which covers physician and other services outside of a hospital. They are burdened by the statutorily-imposed deductibles and coinsurance requirements when they use Medicare-covered services. More affluent Medicare beneficiaries can relieve this burden by purchasing commercial Medicare supplements (so-called "Medigap" policies). Through the original QMB provisions, Congress undertook a deliberate effort to provide needed supplemental coverage for QMBs through Medicaid. *See* H.R. Rep. No. 99-727, 99th Cong., 2d Sess. 105-106, *reprinted in* 1986 U.S.C.C.A.N. 3607, 3695-96 (1986).

B. Because the Acts of Congress in 1986 and 1988 Conflict With Its "Clarifying" Words in 1997, the Ninth Circuit's Deference to the Later Enactment Merits Close Scrutiny.

Congress did not, however, embark on its efforts to assist QMBs by relegating them to a lesser program of benefits. QMBs have always been Medi*care* beneficiaries in the first instance. For this population, state Medicaid programs function in the same manner as a commercial insurer, paying benefits which are supplemental to those of the Medicare program.

Had Congress intended to bring QMBs under the control of state Medicaid programs (and set standards for payment at Medicaid rates), it could have done so directly by renouncing Medicare's primary responsibility for the poor elderly and placing those individuals on the state Medicaid rolls when it made state coverage of QMB cost-sharing mandatory in 1988. That Congress did not do so is consistent with its original intent in enacting the Medicare program in 1965—to address the disparity in health

care access between the elderly with sufficient financial resources and those without. It would be illogical to conclude that Congress, in *expanding* the scope of individuals for whom supplemental coverage would be available through Medicaid (i.e., QMBs), set out to subvert its original design of a single-tiered health insurance program available to all eligible persons on an equal basis.[12]

Beyond its election to maintain the status of QMBs as Medicare beneficiaries, Congress specifically directed the states to pay deductibles and coinsurance for Medicare services provided to QMBs whether or not the specific services otherwise would be covered by the state's Medicaid plan. 42 U.S.C. § 1396d(p)(3). Logically, if Congress had envisioned that a state would be required to pay the Part B cost sharing obligations of Medicare beneficiaries only to the extent of the fees authorized in its Medicaid plan, it would have had no reason to require the state to pay the coinsurance charges for services that are *not* in its plan (i.e., for which the state pays nothing). Instead, the requirement that the states make coinsurance payments for the full panoply of Medicare services is part and parcel of a statutory scheme in which the states are to provide complete supplemental *Medicare* coverage, which includes payment of all coinsurance costs on behalf of QMBs.

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12 This was a touchstone principle in the Second Circuit's first impression analysis of the pre-1997 QMB payment provisions. *Perales*, 954 F.2d at 859 ("Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled and indeed wanted to integrate *all* of those who were Medicare-eligible into the existing health care system.") (emphasis in original). Indeed, a 1997 report prepared by the federal Health Care Financing Administration devotes some 25 pages to a comparison of the demographic, health status, and health spending characteristics of QMBs to those of the *Medicare* population as a whole. Health Care Financing Administration, *A Profile of Dually Eligible Beneficiaries* (March, 1997). No other comparison would make sense—the QMB population is a subset, albeit a less affluent subset, of the elderly and disabled population for whom Congress created the Medicare program.

As it was expanding supplemental coverage for low-income Medicare beneficiaries (i.e., QMBs), Congress simultaneously increased its regulation of private supplemental insurance (so-called "Medigap") policies.[13] In the same 1988 enactment which mandated state supplementation of coverage for QMBs, Congress mandated more extensive federal standards for commercial Medigap policies, including minimum benefit standards.[14] Pursuant to the regulatory scheme initiated in 1988, approved Medigap policies must conform to one of ten standardized benefit designs. Even the most basic of those designs includes full coverage of Part B coinsurance.[15] This 1988 effort to ensure that supplemental insurance for *all Medicare* beneficiaries would cover Part B cost sharing is inconsistent with the retroactive "clarification" of intent in the 1997 Budget Act.

Finally, Congress in 1989 confronted ongoing concerns over low rates of physician participation in state Medicaid programs, mandating a study of the impact of state Medicaid payment policies on the availability of physician serv-

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13 Nearly nine out of ten Medicare beneficiaries hold some form of supplemental insurance to augment their Medicare coverage. Physician Payment Review Commission, *Annual Report to Congress* (April, 1997) at 317. This insurance comes in three forms: individually-purchased commercial Medigap insurance, employer-provided retiree health benefits, and Medicaid. Supplemental insurance covers items, services, and cost sharing that Medicare does not, including deductibles and coinsurance. "Such insurance provides valuable financial protection to Medicare beneficiaries and is associated with better access to care for those beneficiaries who have it." *Id.* For most QMBs, Medicaid is the only available source of supplemental insurance to assure such access.

14 42 U.S.C. § 1395ss, as amended by Pub. L. 100-360 § 221(d), 102 Stat. 744 (1988), Pub. L. 101-234 § 203(a), 103 Stat. 1982 (1989), and Pub. L. 101-508 § 4351(a), 104 Stat. 1388-125 (1990).

15 The federal certification program is based on standards developed by the National Association of Insurance Commissioners. Those standards require all Medigap policies to cover certain "Core Benefits," including Part B coinsurance. *See* 57 Fed. Reg. 37,985, 37,991 (August 21, 1992).

ices for federally-insured populations. Completed in 1991, the study confirmed that inadequate payment rates were the most prevalent reason for inadequate access to physician services under Medicaid.[16] It is difficult to reconcile Congress' 1997 view that, in 1986, it had authorized states to impose Medicaid payment limits on Medicare services to QMBs with its contemporaneous efforts to define problems caused by inadequate Medicaid payment rates.

Congress' actions in 1986 and 1988 are plainly different from its words in 1997. Both legal and civic interests in the regularity of governmental business dealings, as well as interests in ensuring the integrity of benefit programs reaching millions of lives, argue for close scrutiny when Congress seeks to capriciously gainsay the motivations of its original legislative choices. Petitioners' request for guidance regarding the deference due under this Court's precedents to the later-discovered interpretation of the 1997 Congress merits review.

CONCLUSION

For the foregoing reasons and for the reasons stated in the petition of the California Ambulance Association, the California Medical Association, et al., *amicus curiae* American Medical Association respectfully urges that a writ of certiorari issue to review the judgment of the Ninth Circuit in this matter.

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[16] Physician Payment Review Commission, *Physician Payment Under Medicaid*, No. 91-4 (1991) at 21-23. The study reported that state Medicaid fees, overall, averaged about 64 percent of Medicare allowed charges for providing identical services. *Id.* at 35. In evaluating the results, the PPRC observed that Medicaid recipients must obtain physician services in the same market as persons with private health insurance, and cited evidence that, as the discrepancies between Medicaid fees and fees paid by commercial insurers and Medicare are reduced, the numbers of physicians participating in Medicaid, and the proportion of their capacity that physicians will devote to Medicaid patients, increases. *Id.* at 38-39.

Respectfully submitted,

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